CME/ CE

Treating Combat PTSD Through Cognitive Processing Therapy

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Can a therapy initially developed to treat victims of sexual assault help veterans with posttraumatic stress disorder? Here, clinicians who tried this approach pass on their insights.

The VA is the world's largest provider of posttraumatic stress disorder (PTSD) treatment, operating 150 specialized PTSD programs nationwide and providing outpatient PTSD treatment to more than 600,000 veterans annually.[1] Despite these numbers, there is a paucity of research regarding treatment outcomes and a lack of evidence-based psychotherapies in use within VA PTSD treatment programs.[2] Moreover, program evaluations comparing outcomes data from fiscal years 2001 and 2002 reveal meager treatment effects in these VA programs,[1] with the Short Form of the Mississippi Scale for Combat-Related PTSD and a four-item scale constructed specifically for PTSD program monitoring showing improvements of only 3.8% and 6%, respectively.

To address these issues, we conducted a randomized, controlled trial to investigate the efficacy of cognitive processing therapy (CPT), a form of cognitive-behavioral treatment for PTSD,[3] when used to treat veterans with military-related PTSD. Originally developed to treat female victims of sexual assault, the efficacy

At the time of this study, **Dr. Monson** was a clinical research psychologist, **Dr. Price** was a predoctoral psychology intern and a postdoctoral fellow, and **Dr. Ranslow** was a postdoctoral fellow, all at the VA National Center for Posttraumatic Stress Disorder (NCPTSD), Executive Division, White River Junction, VT. Currently, Dr. Monson is the deputy director of the women's health sciences division of the VA NCPTSD, Boston, MA; Dr. Price is an assistant professor in the department of psychology at Georgetown College, Georgetown, KY; and Dr. Ranslow is a staff psychologist at the White River Junction VA Medical Center, White River Junction, VT.

CONTINUING MEDICAL EDUCATION and CONTINUING EDUCATION

GOAL

To review the theory behind cognitive processing therapy (CPT) and provide several insights into using this evidence-based posttraumatic stress disorder (PTSD) treatment for veterans affected with combat PTSD.

OBJECTIVES

After reading this article and taking the appropriate test (CME on page 84 or CE on page 86), all physicians and other health care professionals should be able to:

1. Describe the tools of CPT and beyond of its components.
2. Identify challenges of using CPT to manage combat PTSD and discuss strategies for overcoming them.
3. Understand how dual diagnoses, such as substance abuse, can affect outcomes when CPT is used to treat PTSD.

ACCREDITATION

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint sponsorship of Albert Einstein College of Medicine and Quadrant HealthCom Inc. Albert Einstein College of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

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CME/CE PEER REVIEW

This article has been peer reviewed and approved for CME credit by Gary Kennedy, MD, professor of medicine at Albert Einstein College of Medicine, Bronx, NY. Review date: September 2005. **Dr. Kennedy reports receiving grant/research support from Forest and Janssen and being a member of the speakers bureau for Pfizer.**

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CONFLICT OF INTEREST STATEMENTS

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CME test on page 84 CE test on page 86

of CPT has been minimally tested outside of this population or outside of academic research settings.[4,5] In adapting CPT for veterans with combat-related PTSD, we encountered some issues that were distinct from those reported previously by researchers studying the use of CPT to treat sexual assault victims.

Here, we share five lessons that we learned through this endeavor. With the intention of increasing clinician comfort and knowledge about applying similar evidence-based treatments to patients in this setting, we discuss traumatized veterans' ability to tolerate trauma-focused treatment, beliefs about emotional experience and expression, distrust of the treating institution, beliefs about disability and compensation as it relates to PTSD, and acts of violence committed in the context of traumatization. In doing so, we use case examples, provide empirical research, and detail strategies for overcoming barriers to implementing a trauma-focused treatment such as CPT to manage combat PTSD in veterans. First, however, we will take a closer look at CPT and describe our study.

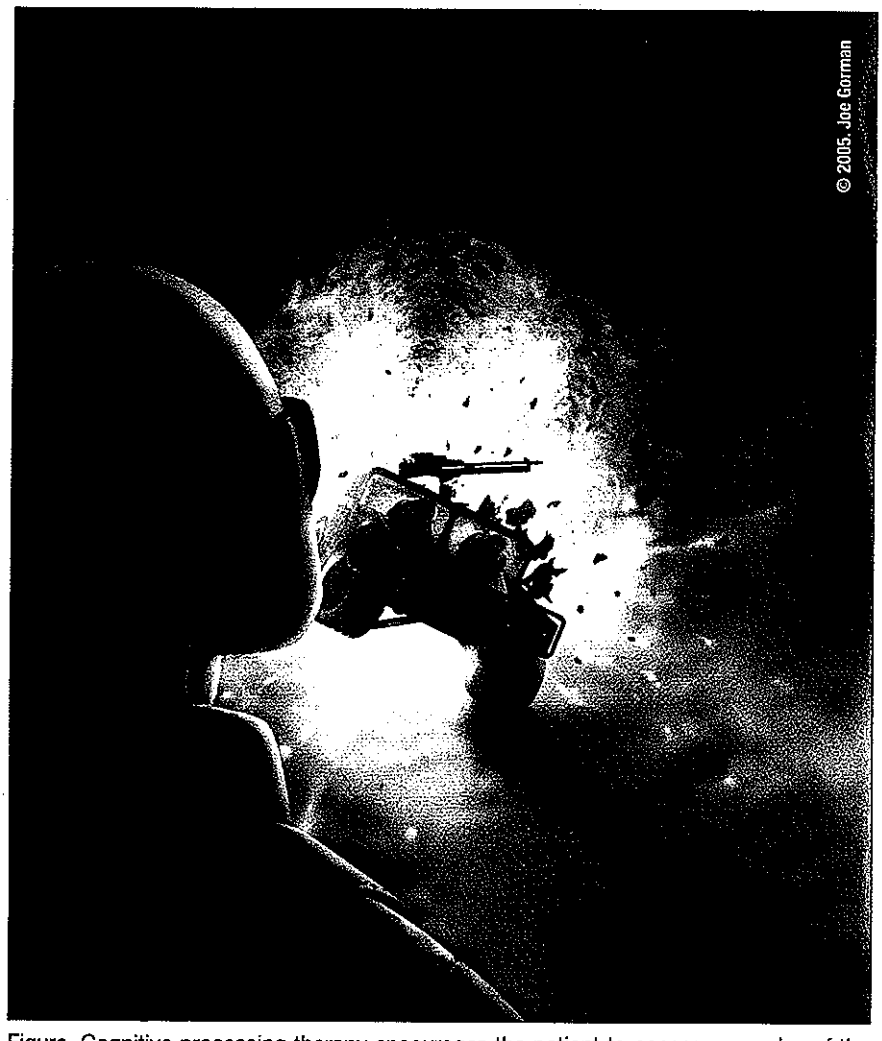

Figure. Cognitive processing therapy encourages the patient to access memories of the traumatic event—and to recognize and feel the associated emotions so that they eventually dissipate. To facilitate emotional processing, this therapy targets dysfunctional beliefs about the event, the patient's own self, others, and the world.

COGNITIVE PROCESSING THERAPY

Patricia Resick developed and tested CPT in the early 1990s as a trauma-focused cognitive-behavioral treatment for PTSD symptoms in sexual assault victims. CPT is grounded in an information processing theory of PTSD. Rather than regarding PTSD symptoms as the result of a readily potentiated fear schema, CPT treats them as either (1) a consequence of a patient's inability to resolve conflicts between the traumatic event and beliefs about self or others that were held prior to the trauma or (2) confirmatory information for previously held dysfunctional beliefs.[6]

The therapy focuses on accessing memories of the traumatic event—and on recognizing and feeling the associated emotions so that they eventually dissipate. To facilitate emotional processing, CPT targets dysfunctional beliefs about the event, the patient's own self, others, and the patient's world (Figure).[6] The treatment manual[3] combines these components in 12 60-minute psychotherapy sessions. Although patients write about the impact of their traumatic event(s) after the first session and about the details of their trauma(s) in subsequent sessions (Table), the treatment is primarily cognitive in nature, targeting specific thoughts and beliefs that interfere with the patient's emotional processing of these events.

OUR STUDY DESIGN

We administered our study treatment and collected data at the White River Junction VA Medical

Center, White River Junction, VT from January 2003 through March 2005. Our study had a wait-list design: 60 male and female veterans were randomly assigned to receive CPT immediately or to wait 10 weeks to receive the therapy. To qualify for the study, veterans must have had an index military trauma, though the majority of participants experienced other traumatic events prior and subsequent to their military service. As is standard in psychotherapeutically based trials of PTSD, patients were excluded if they had a substance dependence that had not been in remission for at least three months, a current uncontrolled psychotic or bipolar disorder, a cognitive disorder, or prominent suicidal or homicidal tendencies.

During the trial, participants were able to continue with a stable psychopharmacologic regimen and with psychotherapy and self-help groups not specifically focused on treating PTSD. Given the relatively inclusive eligibility criteria and the low number of patients deemed ineligible, we consider our patient sample to be representative of VA outpatients and hope our findings are generalizable to practice in other federal health care settings.

LESSON 1: TRAUMA-FOCUSED TREATMENT CAN WORK

A recent survey of 902 psychologists reported that 649 (72%) were "not at all comfortable" with imaginal exposure techniques for PTSD treatment.[7] This discomfort appears to be based on the belief that exposure treatments may increase patients' fear and anxiety to dangerous levels, ultimately worsening symptoms.[7–9] This concern persists despite a growing body of literature demonstrating that when trauma-focused treatments are carried out correctly, they are rarely associated with symptom exacerbation[10] or treatment dropout.[11]

Medical literature offers little prescriptive guidance for predicting patient responses to trauma-focused treatment. Efforts to elucidate factors associated with response to PTSD treatment have yielded few, if any, consistent results.[12]

On the contrary, accumulating data suggest that patients who might be considered poor candidates for the current evidence-based PTSD treatments may benefit from trauma-focused treatment. For example, patients with a history of developmental trauma and complex trauma symptomology—as well as those without this history and presentation—have responded to CPT.[13] In fact, these patients have demonstrated improvements in personality disorder symptoms and complex trauma symptomology (such as interpersonal problems, sexual dysfunction, and self-harm), which are beyond those typically studied in PTSD trials.[13,14]

In our experience, it is not unusual for clinicians to underestimate their patients' ability to tolerate and benefit from a trauma-focused intervention. Throughout our study, we were humbled by our own inability to predict the degree to which certain patients would benefit from CPT. In one such instance, the long-term therapist of a patient with a history of severe PTSD, dissociation, suicidal ideation, and psychiatric hospitalizations cautiously referred his patient to our study. Committed to the notion of our results being as generalizable as possible, we accepted the patient. The CPT-study therapist closely observed the patient for signs of dissociation (especially when the patient read the account of his own trauma aloud) and used such grounding techniques as saying his name, orienting him to the room,

Table. Topics covered, by session, throughout cognitive processing therapy

Session(s)	Content
1	Provide psychoeducation regarding posttraumatic stress disorder (PTSD) and rationale for treatment, assign writing about meaning of trauma (i.e., impact statement)
2	Introduce cognitive model of PTSD
3–4	Assign writing about the patient's specific trauma and review this account to access various associated emotions and beliefs, begin cognitive challenge of dysfunctional/irrational associated beliefs
5–6	Provide patient instruction and support for self-challenge of trauma-associated dysfunctional/irrational thoughts and beliefs
7–12	Challenge by therapist and patient of any overgeneralized beliefs related to safety, trust, power, control, esteem, and intimacy, patient rewrites impact statement, final review and consolidation of treatment gains

and monitoring his body responses to keep the patient engaged in the session. The patient was able to tolerate the intervention in its entirety, and by the end of therapy, rarely dissociated in response to reminders of the traumatic event.

To ensure patient safety and to reassure the referring provider that the patient was safe, we encouraged patients to check in with their providers and invited patients to check in with their CPT therapist between sessions as needed. We also held educational sessions for referral sources to discuss their concerns and provide information about the theory behind CPT, as well as strategies for responding to complex clinical cases.

We encouraged patients to educate their loved ones about the treatment and its rationale and to seek support from them.

We often reminded patients and their providers that the patients had already spent much time thinking about their traumatic events; CPT allows them to think about the trauma in a controlled and therapeutic manner. We encouraged patients to educate their loved ones about the treatment and its rationale and to seek support from them. On occasion, we spoke with significant others to assuage any concerns they might have about their loved one participating in trauma-focused therapy and to discourage them from colluding with the patient's avoidance (for example, interfering in a homework assignment designed to help the patient fully experience all feelings related to the trauma by telling the patient not to get himself or herself too upset). Our efforts to encourage a collaborative relationship between clinicians, clinical researchers, and patients' loved ones allowed for greater confidence in the safety and potential effectiveness of the treatment.

LESSON 2: ADDRESS PATIENT BELIEFS ABOUT EMOTIONS EARLY ON

Throughout our study, we noticed that many male participants tended to hold beliefs about emotional experience and expression that could interfere with the effective delivery of CPT. Consistent with findings that male veterans are likely to accept traditional male gender roles, which are reinforced by military training and culture,[15] we encountered a number of men who held such beliefs as "Real men don't cry" or "If I cry, I'm weak." These beliefs can obfuscate the emotional processing necessary to ameliorate PTSD.

We found that cognitive restructuring techniques aimed directly at these beliefs could facilitate emotional engagement. For example, at the beginning of his fourth therapy session—which was to focus on his written trauma account—a male veteran stated that he had trouble accessing his emotions about his combat trauma. After he read his account aloud, the following conversation transpired:

Therapist: "I noticed that as you read your account, you seemed to be fighting back tears."

Patient: "I know. I have to try hard not to cry when I think about it."

Therapist: "Remember that the purpose of writing and reading the account is to help yourself feel your emotions like you felt them when the event was happening."

Patient: "Yeah, but I can't let myself cry about it."

Therapist: "Why is that?"

Patient: "Because crying is weak."

Therapist: "Why do you say that?"

Patient: "It just is. Real men don't cry."

Therapist: "Do you have evidence for this?"

Patient: "Evidence? What do you mean? It's a known fact."

Therapist: "Let's take a second and consider something. Have you ever seen a man cry in front of you or others?"

Patient: "Yeah, one of my group members cried a couple of weeks ago."

Therapist: "And how did the group respond?"

Patient: "They nodded and understood where he was coming from. They've been there; they're vets too."

Therapist: "Did you or others think he was weak?"

Patient: "No."

Therapist: "Is he a real man? You mentioned he was a veteran in your group?"

Patient: [laughing] "Yes, he's a real man. I see where you're going."

Therapist: "How do you imagine I would respond if you shared your emotions?"

Patient: "I don't know. I guess you'd understand it too."

Therapist: "Absolutely. Even though you might feel weak, it actually takes incredible courage and strength, not weakness, to experience and express your emotions. It sounds like you have evidence showing that other men believe this as well."

Patient: "Well, I don't know if I believe that yet or not, but I'll keep trying."

Eventually, this patient did cry during his session, and this provided an opportunity to explore further his underlying beliefs related to emotional expression and weakness. Challenging beliefs about emotions early on allowed him to process a greater degree of emotional material and was critical in maximizing the effects of CPT's exposure aspect.

In addition to anxiety, numerous other emotions can arise from traumatic experiences.[16] Although female veterans in our trial did express anger related to their traumatization, we found a greater tendency to experience and express emotions in the anger or externalizing spectrum—such as rage, resentment, and hatred—among the male veterans. Irrespective of gender, participants frequently expressed feelings of suspiciousness toward the federal government, the VA, and, sometimes, its providers.

Whatever the patient's emotional response to treatment, it may be accompanied by defensiveness, which has important implications for the Socratic technique that is characteristic of cognitive interventions and key to CPT. With defensive patients, we have found that a "Columbo" approach to questioning ("I don't know, but I wonder...") works well. When possible, it also is advantageous to have patients play their own devil's advocate, taking increased ownership for their cognitive challenging. This is ultimately more beneficial to the patients as it helps them integrate the skill into their daily lives. Timing is also key. If a patient seems particularly reluctant to challenge his or her way of thinking about certain emotions, it can be helpful to table that sticking point by saying something along the following lines: "I can see it would be helpful for us to come back to this discussion at a later point."[17]

LESSON 3: ADDRESS DISTRUST OF THE FEDERAL GOVERNMENT

Issues of distrust and suspicion of government institutions certainly can complicate the treatment of veterans within the VA. Patients may view the therapist as both an ally who is helping them with PTSD and an authority figure who represents an institution that facilitated, caused, failed to recognize, or denied them compensation for their traumatization. This dual role can lead the patient to question whether the therapist's allegiance is to the patient or to the institution—and to worry about the therapist's potential to wield and misuse power.

It may be tempting for a therapist to minimize or dismiss his or her role as a member of the mistrusted institution, but we advise against this, as the patient may construe this as equivocation and furtiveness. Instead, we encourage open discussion of this subject between therapist and patient. Such discussions may mitigate patient concerns and may provide content for cognitive interventions. Although issues of distrust may not be resolved completely, a therapist's openness to address them can help patients more fully participate in the therapy.

The cognitive tendency to overgeneralize is particularly relevant to this issue of distrust. One patient was reluctant even to enroll in our study because of his misgivings about the VA and researchers and therapists employed by the VA. During CPT, we challenged his overgeneralization by exploring instances of positive experiences with individuals working for the distrusted institution. This was addressed in the initial session with this patient as treatment expectations were discussed.

Therapist: "What are some of your thoughts about pursuing this therapy based on what I've said so far?"

Patient: "I doubt it will work. The VA is why I have these problems to begin with. Plus, I've been in lots of therapies for PTSD and nothing has worked so far. Why should I believe this would help me now?"

Participants frequently expressed feelings of suspiciousness toward the federal government, the VA, and, sometimes, its providers.

Therapist: "It makes sense that you would be wary based on your experiences with VA treatment in the past. Do you have any reasons to believe CPT could work?"

Patient: "A guy in my group said it helped him."

Therapist: "Okay, so that's a good sign. And what about reasons to trust me when I say we think this therapy could be helpful for you?"

Patient: "I don't know; you're part of the system."

Therapist: "Yes, and is every person associated with the VA guaranteed to fail you in the end?"

Patient: "They have so far."

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Therapist: "Every person? Can you think of anyone you've worked with at the VA who has done anything to help you?"

Patient: "The guy who leads my group is alright. He's always there for us."

Therapist: "Good, so maybe just because I'm part of the system, I can still be trusted when I tell you that I believe CPT could help you?"

Patient: "Yeah, maybe so."

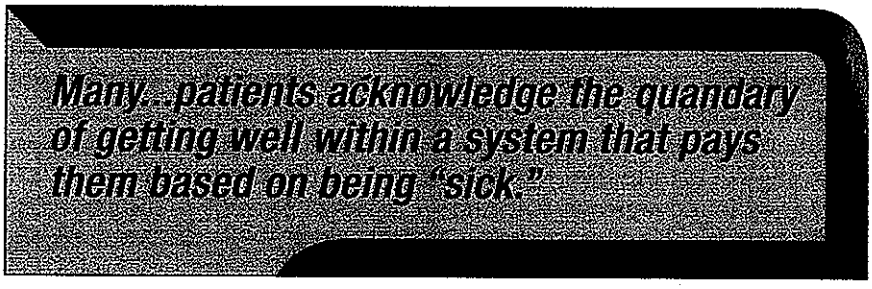
Therapist: "Maybe we should adopt a 'wait and see attitude' instead of writing off the possibility of you getting better."

These cognitive strategies can help alleviate the impact of distrust on the potential progress of the therapy. We have found that, within the context of a good therapeutic relationship with a strong emphasis on collaboration, veterans can engage in and feel empowered by the structure of CPT and satisfied with its results.

LESSON 4: INCORPORATE BELIEFS ABOUT DISABILITY DUE TO PTSD

Efforts to obtain or maintain compensation and benefits for disability related to mental health have the potential to influence any treatment. To our knowledge, only two research studies have investigated the association between seeking disability compensation and PTSD treatment outcomes. Using data from VA specialized PTSD treatment programs, Fontana and Rosenheck found that seeking disability compensation was associated with poorer outcomes among veterans enrolled in long-term inpatient programs, but not those in standard outpatient and short-stay inpatient programs.[18] Similarly, DeViva and Bloem found that seeking compensation was not associated with PTSD treatment outcomes among outpatient combat veterans.[19]

Nearly all of the patients in our trial received some type of VA benefits, with the majority rated as 100% severely and permanently disabled. Many of these patients acknowledge the quandary of getting well within a system that pays them based on being "sick." We consider CPT to be sufficiently flexible to address this disability bind in which patients and therapists sometimes find themselves.



We encourage therapists to raise and openly discuss disability and compensation issues in session and to use the cognitive interventions to motivate change within the context of a system that may reinforce sickness. Sample questions include: What do you think it means to be "100% permanently and severely disabled," according to the VA? Does it mean that you're 100% disabled in all ways? Does it really mean that you're disabled in this way forever? Do you think you can get better? What keeps you from changing? What entices you to change? Is it possible for you to get better and still receive your compensation? Can your functioning and coping change, even if the PTSD doesn't?

Patients often reported that they had been sick for decades and were told by previous providers that they would suffer from PTSD for the rest of their lives. In response, we question, "Have you ever directly confronted what has caused your PTSD symptoms? Have you ever participated in a type of psychotherapy that research has shown to improve PTSD? Let's keep the jury out until you've participated in that kind of treatment."

Even when these strategies are used, the challenge of delivering treatment within a health care system that provides disability payment remains. Within such a system, we must find ways to motivate patients to change, even if only in small increments, by focusing on functioning instead of symptomology.

LESSON 5: COMMITTING ACTS OF VIOLENCE CAN BE TRAUMATIC

Veterans differ from other populations on whom a trauma-focused treatment might be used in that they are far more likely to have committed acts of violence within the context of their traumatic situation. War is, in essence, sanctioned violence. The rules of engagement, however, are not always clear when applied to specific circumstances.

We certainly have encountered cases in which the gratuitous nature of the violence perpetrated by the patient was obvious—for example, when a patient removed body parts from dead enemy soldiers to keep as "souvenirs." In cases such as these, an acceptance-oriented approach involving forgiveness has been effective. These cases aside, however, it has been our experience that many

combat veterans seeking treatment struggle with the notion of being both a perpetrator and victim of violence. Supporting this observation, research indicates that veterans who killed others during their military service have more severe PTSD symptoms than veterans who did not.[20]

One illustrative case involves a Vietnam veteran with a core belief that he was essentially an evil person. He directly traced this belief to his worst traumatic experience, in which he and his fellow soldiers were faced with having to shoot children with backpacks containing bombs. In another case, a veteran shot an enemy in "black pajamas with a hood," only to find out later that the enemy was a woman with a child on her back. The veteran's belief was that he had "murdered" a woman and child, which was in direct opposition to his values regarding violence against women and children. This left him with the sense that he was a horrible person, which fueled his severe PTSD symptoms and intense guilt.

For these and other cases involving acts of violence, we paid special attention in therapy sessions to attributing responsibility and blame. We do not work to modify the patient's cognitions related to his or her responsibility for committing acts of violence since accepting such responsibility is part of successful therapy. Rather, our Socratic questioning and restructuring is geared toward the intentionality of the patient's behavior, as well as the context surrounding the traumatic event. Since much of combat violence involves firearms, we often used general scenarios involving shooting a gun to illustrate these concepts in sessions.

Therapist: "If someone dies, and you plot their death, stalk them, and shoot them, what do we call this?"

Patient: "Murder."

Therapist. "Right. Probably first-degree, as there is responsibility and premeditation."

Therapist: "If someone dies because you're drunk, you pick up a gun without realizing it's loaded, and you shoot them, what do we call that?"

Patient: "Hmmm...I don't know."

Therapist: "We would consider this manslaughter—there is responsibility, but you didn't intend to shoot them."

Therapist: "If someone dies because you are target shooting and they run in front of you, what do we call that?"

We do not work to modify the patient's cognitions related to his or her responsibility for committing acts of violence since accepting such responsibility is part of successful therapy.

Patient: "An accident."

Therapist: "That's right. Now, what if someone was told to shoot you, and you shot him before he shot you? What would we call that in a court of law?"

Patient: "Self-defense."

Therapist: "Right. And, how does that fit in with all of the circumstances in which you found yourself during combat?"

We also worked with veterans who believed that killing or hurting anyone during a combat tour made them murderers or perpetrators. In these cases, we targeted hindsight bias by helping them to consider the events surrounding their participation in combat. Again, a Socratic line of questioning is used, such as: What were your beliefs, values, and knowledge as an 18-year-old? What other choice did you really have then but to be drafted or to enlist? Your beliefs are different now, based on 35 years (in the case of many Vietnam veterans) of knowledge and experience. Is it fair to apply your current standards and beliefs to the person you were then?

Some patients with religious beliefs cited teachings and scriptures to buttress their beliefs that they were murderers. As our sample primarily consisted of individuals with Judeo-Christian beliefs, references to the commandment, "Thou shalt not kill" and the Bible verse regarding "turning the other cheek" were common. In such cases, we had some success citing biblical examples of God using violence under certain circumstances (for example, Noah and the ark or Moses and the plagues). These challenges were integrated easily into the CPT framework and are consistent with its overall aim of testing patients' inherent beliefs.

THE PTSD-SUBSTANCE ABUSE CONNECTION

Based on our experience, we concur with authors who have noted differ-

ences in providing psychotherapy within an efficacy trial versus within clinical practice.[21] One of the fundamental issues raised is that patients included in a clinical trial are unlike those in the general population due to exclusionary parameters—such as substance dependence.

There have been recent efforts to integrate PTSD and substance abuse treatment,[22,23] and we believe that evidence-based treatments for PTSD, including CPT, hold potential for treating patients with this dual diagnosis. Key to success is that attention must be paid to both diagnoses. In our study, for example, though we treated only a few patients with comorbid substance abuse problems (only current substance dependence was an exclusionary diagnosis), we clearly indicated at the outset that we would monitor their substance use throughout treatment and conceptualize their use as a method of avoidance and dysfunctional self-soothing. We incorporated their cognitions related to using substances and emphasized the consequences of their use in CPT sessions focused on cognitive restructuring.

The topic of "intimacy," which is addressed specifically within the last six CPT sessions, is especially well suited to highlighting the connection between traumatization and substance use. Poor self-intimacy involves destructive methods of self-soothing and emotion regulation—one such method being substance abuse. In our trial, patients who reported substance abuse as a coping strategy generally reported that their use of substances decreased as a result of treatment.

POINTS TO REMEMBER

It is important to note that patients require a certain amount of stability and safety in order to embark on any trauma-focused PTSD treatment, not only CPT. Caution should be exercised when this type of therapy is used to treat patients exhibiting prominent suicidality, homicidality, self-injurious behavior, or substance dependence. Staged treatment models that begin with crisis management and skills-focused interventions may be more appropriate for such patients.[24] If any other reasons are presented for not pursuing CPT or another trauma-focused treatment, it is worth considering patient avoidance—or inadvertent clinician collusion with the patient's anxiety-avoidance cycle.

In applying CPT to a veteran population, we learned the importance of individualizing the treatment to the patient. To accomplish this, we provided completed homework sheet examples that were relevant to the veteran population.

The value of good psychotherapeutic elements also cannot be overlooked. There is no substitute for the foundation of a solid therapeutic alliance involving rapport, support, understanding, and empathy.

Several veterans have told us at the end of their treatment, "This has totally changed my life and the way I see things. I only wish they would have had this for me when I came back 30 years ago." It is our hope that evidence-based practices like CPT will be made more widely available for those veterans who returned decades ago and for the expected large number of new veterans with PTSD who are likely to seek services from the VA over the next several years. To that end, we hope that others can benefit from our experience treating veterans with this evidence-based PTSD treatment. ●

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